Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

REPLY COMMENTS OF ALASKA COMMUNICATIONS

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Executive Summary

The Commission's *Notice* acknowledges the diminishing resources and disturbing healthcare trend lines in rural America, and the myriad benefits that affordable telemedicine has the capability to enable, where it is available. But, the medical care and related resources necessary to meet the needs of rural residents in Alaska cannot be delivered without support from the Commission's Rural Health Care Support Mechanism. The Commission has a key role to play in expediting the processing of pending funding requests and, with prompt resolution of this rulemaking, ensuring that future support is both sufficient and predictable to meet the modern telecommunications needs of healthcare providers. With the *Notice*, the Commission shows that it wants to respond to the rural healthcare crisis by increasing available funding, eliminating outmoded rules, and increasing the efficiency of this program.

However, even as the *Notice* acknowledges the many ways in which the Rural Health Care Support Mechanism's antique Telecom Program rules are broken, the Commission proposes "reforms" that would, in some ways, make that Program more difficult and complicated for rural healthcare providers to use, while increasing compliance risks and reducing support.

Alaska, the largest and most rural state in the nation, feels the crisis in rural healthcare more acutely than any other. The state's rural healthcare providers have embraced telemedicine out of necessity, early and wholeheartedly. Supported rural healthcare projects in Alaska showcase the lifesaving benefits the Commission's mechanism can deliver for the nation's rural, remote, and native communities. The Chairman of the Federal-State Joint Board on Universal Service says that he is "cautious when suggestions are made to take funding from [Alaska,] a portion of the U.S. that is unlike any other in our Union.[1] Nevertheless, Alaska's rural healthcare

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[1] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, FCC 17-164, 32 FCC Rcd 10631 (2017), Statement of Comm'r O'Rielly.

providers have languished for eight months and more with no Rural Health Care support whatsoever.

Last year, the Commission improvidently used $100 million of potential rural healthcare funding to buy a fleeting and insignificant three-month reduction in the contribution factor. Now that the money is gone, the Commission recognizes the need to roll unused funds from the RHC budget forward, to meet future needs. Still, it is not clear how much support this will effectively make available for rural healthcare providers with pending projects.

Rural America's healthcare crisis demands immediate and constructive Commission action. The Commission should sufficiently budget for the Rural Health Care Support Mechanism to meet the demand for 2017 and the anticipated growth in future years. Reform of the Telecom Program should bring those rules in line with market realities, relying primarily on competitive bidding to discipline rates for competitive service markets, backstopped by reasonable rules that address market failures, increase transparency, and ensure that rural healthcare providers gain access to the lowest rates for comparable services in the market. To make the Telecom Program more efficient, the Commission should streamline its regulations, as it has done whenever telecommunications markets have grown competitive.

Equally important, the Commission should impose predictability and transparency on USAC's processes. The Commission should create standard filing windows for RHC funding requests that close sufficiently in advance that funding commitments can be issued before the funding year starts, codify binding deadlines for USAC issuance of funding decisions and appeals, and direct USAC to make basic information and statistics about funding demand, service prices, the use of past funding, and its progress in reviewing applications.

Finally, the Commission should avoid the disruptive effects that changes to the definition of "rural" could create, and expand the reach of the Telecom Program to encompass sensible, money-saving patient home monitoring and "Hospital-at-Home" services.

These approaches would truly modernize the Telecom Program and deliver critically-needed aid to those on the front lines of America's rural healthcare crisis.

Table of Contents

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Alaska Communications[2] hereby offers these reply comments on the Commission's proposals for reform of the Rural Health Care ("RHC") universal service program.[3]

Introduction

The record built in the initial comment round of this proceeding confirms the vital importance of the Commission's rural healthcare support mechanisms in improving rural quality of life, reducing rural healthcare costs, and saving lives. In these reply comments, Alaska Communications reemphasizes the great need for the Commission to increase the size of the rural healthcare budget, adopt sensible safeguards against abusive, monopoly rates in non-competitive areas, regain the program's focus on the needs of rural patients and rural healthcare providers, and modernize the program's structure to reflect the current marketplace for secure, reliable, packet-based services with sufficient bandwidth to support today's telehealth and telemedicine services.

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2 In these reply comments, "Alaska Communications" represents the following wholly-owned subsidiaries of Alaska Communications Systems Group, Inc.: ACS of Alaska, LLC, ACS of Anchorage, LLC, ACS of Fairbanks, LLC, ACS of the Northland, LLC, and Alaska Communications Internet, LLC, all of which participate in the provision of services to rural health care providers in Alaska.

3 *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, FCC 17-164, 32 FCC Rcd 10631 (2017) (the "*Notice*" and "*Order*"). As used herein, the "*Notice*" refers to the substantive portions of this document that comprise the Notice of Proposed Rulemaking, paragraphs 15 through 106, as well as the Introduction and Background sections, paragraphs 1 through 14; and the "*Order*" refers to the portions, in particular paragraphs 107 through 117, that make up the substantive portions of the Order.

Discussion

I. The Record Reflects Widespread Consensus that the Benefits and Demands of Rural Telehealth and Telemedicine Necessitate Reform and Substantial Increase to the Rural Healthcare Support Budget

As affirmed by numerous commenters, the current $400 million rural health care budget is not sufficient to ensure that telecommunications and other advanced services that enable telehealth and telemedicine are affordable to the nation's rural healthcare providers. The record demonstrates the need for immediate FCC action to raise the budget for the coming funding year, which begins in just four months, as well as for rule changes to ensure that the budget will keep pace with demand in future years.

A. The Commission Must Act Immediately to Provide Sufficient Telecom Program Funding for FY2017 and Beyond

The Telecom Program is not only vital to Alaska, it is mandated by statute.[4] For that reason alone, the Commission must reject the suggestion from Kellogg & Sovereign to phase out the Telecom Program.[5] As currently structured, the healthcare connect fund ("HCF") simply cannot take the place of the Telecom Program. USAC data show that the gradient between urban and rural rates for broadband services in Alaska is sufficiently steep that the 65 percent subsidy offered under the HCF simply cannot make services affordable to rural Alaskan HCPs or make rates reasonably comparable to those prevailing in Anchorage, as required under Section 254(h)(1)(A).[6] Therefore, the record strongly supports retention of the Telecom Program, as

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4 47 U.S.C. § 254(h)(1)(A).

5 Kellogg & Sovereign Comments at 8.

6 Alaska Communications supports the proposal by SHLB to create a 95 percent support tier within HCF. SHLB Comments at 16. Alaska Communications believes that it should apply to the entire state, without regard for any purported degree of "rurality." Even so, USAC data show that, even 95 percent support is not sufficient to close the urban-rural rate gap, as required by Section 254(h)(1)(A), or to make services affordable to rural HCPs in all cases.

well as several concrete steps the Commission should take to strengthen it, as described below and in the initial comments filed by Alaska Communications.

1. The Communications Act Does Not Permit the Commission to Impose a Cap on Telecom Program Support

To avoid irreparable harm to rural Alaskans and the essential network of creative, efficient telemedicine services on which they rely, the Commission must act immediately to provide sufficient funding to ensure affordable telecommunications connectivity under the Telecom Program in particular. Every day without a solution, every dollar of *pro rata* funding reduction, produces greater strain on rural healthcare providers, harming patient health, impeding delivery of needed care, and jeopardizing the telehealth systems that HCPs have deployed or planned. Rural health clinics defer the purchase of broadband services they require.[7] Financial uncertainties cause health care providers to defer other investments, curtail hours, layoff staff, or otherwise reduce services.[8] Service providers accrue month after month after month of accounts receivable, yet must incur real financial costs to remain current with third-party suppliers of

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7 *E.g.,* Alaska Communications Comments at 7-8.

8 *E.g.,* H.J. Res. 14, 30th Leg., 1st Sess. (Alaska 2017) (finding that an increase in the Rural Health Care Support mechanism cap is necessary to " ensur[e] that rural communities in the state continue to have access to affordable broadband telehealth services, critical for improving access to care"); *Ex Parte* Letter of Alaska Primary Care Ass'n, WC Docket No. 02-60 (filed May 24, 2017 ("[P]roration of the current 7.25% to 10% - or more - would force rural health practices to lay off staff, limit lines of service, and decrease access to care in order to afford their current level of connectivity. Or they will simply revert to expensive, slow, inefficient models of care from decades ago, where telemedicine, Electronic Health Record use, and Imaging in frontier areas is conducted by collecting data in the field and then transmitted to the EHR and specialists after the teams fly back to their home base clinic."); *Ex Parte* Letter of Tanana Chiefs Conference, WC Docket No. 02-60 (filed May 24, 2017 (explaining that proration "will directly impact our patient programs in cuts to personnel, programs, and direct health services").

wholesale services necessary to reach their HCP customers.[9] And, in the end, rural residents pay the price, while the rural telehealth services on which they depend hang in the balance.

The Commission therefore should immediately – before resolving the great host of other issues presented in this docket, before another year of funding commitments falls victim to seemingly interminable delays – act to lift the cap on Telecom Program funding for Funding Year 2017 and beyond.

Experience has revealed two key failings of the *pro rata* funding reductions rule[10] that should cause the Commission to scrap it immediately. *First,* full funding of Telecom Program demand is compelled by the Communications Act, which mandates that rural telecommunications rates for HCPs be "reasonably comparable" to those available for the same or similar services in urban areas, without regard to the cost of meeting that standard.[11] Thus ,the support necessary to meet this standard may not be artificially constrained by the Commission's self-imposed budget cap.

In this respect, Alaska Communications agrees with SpaceX that the statute "does not require the Commission to treat the Telecom Program and the HCF Program differently"[12] But, the Telecom Program was designed to implement the mandatory support required by Section 254(h)(1)(A) of the Act to ensure rural healthcare providers have access to the telecommunications services they need at rates that are reasonably comparable to the rates for

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9 Alaska Communications Comments at 7.

10 47 C.F.R. §54.675(f).

11 47 U.S.C. § 254(h)(1)(A). *See, e.g.,* SHLB Comments at 15; GCI Comments at 16-17; ADS Advanced Data Services ("ADS") Comments at 1; Southcentral Foundation Comments at 3; Norton Sound Health Corp. Comments at 3; Council of Athabascan Tribal Governments Comments at 4; TeleQuality Comments at 8; Alaska Communications Comments at 23.

12 SpaceX Comments at 6.

similar services in urban areas of the same state.[13] In contrast, the HCF Program is based on Section 254(h)(2)(A) of the Act, which requires the Commission to consider whether support is "economically reasonable."[14] While the FCC should fully fund the needs of both the Telecom Program and HCF, the FCC must, if it retains budget constraints on the RHC mechanism, prioritize Telecom Program funding over HCF.

Second, full funding of Telecom Program demand is sound public policy. The record is replete with examples from rural healthcare providers of efficiency gains and improved patient outcomes made possible through telehealth initiatives supported in part by this program. Rural residents experience higher rates of diabetes, hypertension, obesity, cancer, total tooth loss, injury, smoking, physical inactivity, poor diet and limited use of seatbelts.[15] With support from the Telecom Program, access to telehealth services permits the efficient delivery of preventative and palliative care, diagnostics, treatment, and monitoring, all resulting in improved patient outcomes, lower overall medical costs, reduced records retention and retrieval costs, and fewer travel costs.[16] These savings redound to the benefit of many federal programs (Medicare, Medicaid, the Veterans Administration) as well as in state and local government-sponsored programs.[17]

The suggestion that such savings are not the FCC's concern because this agency itself does not "recoup any of the savings to help offset our costs" is stunningly narrow.[18] Given the

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13 47 U.S.C. § 254(h)(1)(A).

14 47 U.S.C. § 254(h)(2)(A).

15 NTCA Comments at 3.

16 Alaska Native Tribal Health Consortium Comments at 5; South Peninsula Hospital Comments at 3.

17 South Peninsula Hospital Comments at 3.

18 *Notice*, Statement of Commissioner O'Rielly, at p. 81.

FCC's broad statutory mandate to serve the public interest, and the goals of the *Notice* to "root out inefficiencies and target support where it is needed most," the Commission may and should take into account all the benefits of its policies for the advancement of universal service.[19] The statute broadly mandates that rural healthcare providers have access to the telecommunications services that are "necessary" for the provision of healthcare services at rates that are reasonably comparable to the rates in urban areas.[20] It does *not* mandate that the Commission limit such access to a predetermined annual budget, nor constrain the program to any particular size.

In contrast, failure to fully fund the Telecom Program is a violation of the statute that has created a crisis in rural healthcare, particularly in Alaska. In both Funding Years 2016 and 2017, USAC was unable to process RHC funding requests in a timely manner, creating grave hardships for rural healthcare providers (and potential harm to their patients), and undermining the statutory goals of the support mechanism. As ANTHC explains, the funding shortfall and resulting *pro rata* reductions in support for Funding Year 2016 not only proved costly that year but also created great uncertainty for rural HCPs and service providers for Funding Year 2017 and beyond. The shortfalls "potentially leav[e] tribal HCPs with considerable costs," while service providers likewise need program stability to "allow them to continue to invest in infrastructure, eventually bringing costs down as connectivity expands."[21]

The long-delayed results already represent great administrative cost to the FCC and USAC. For Funding Year 2017, in particular, USAC has spent over eight months and counting – undoubtedly costing many millions of dollars in staff and contractor resources – scrutinizing

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19 *E.g.,* 47 U.S.C. §201(a), 201(b), 214(a), 254(b), 254(h).

20 47 U.S.C. § 254(h)(1)(A).

21 ANTHC Comments at 9.

funding requests, and this work continues, even with the large majority of the funding year now behind us. The key failing of the *pro rata* reduction process is that USAC has been unable to publicly decide *anything* until they have privately decided *everything* regarding each year's funding requests, causing unacceptable delay and denial of service. While efforts to begin the process earlier and streamline review may accelerate the process incrementally, experience shows that there is simply not enough time in a single year both for HCPs to complete the competitive bidding and funding request cycle, and for USAC to complete its review, calculate *pro rata* reductions, and issue timely funding commitments. Full funding of the Telecom Program will at least alleviate delays attributable to the *pro rata* allocation process.

As further indication of the short-sightedness of *pro rata* reductions, the statute entitles service providers to offset the full amount of the difference between the urban and rural rate against their universal service contribution obligations, regardless of the level of funding available as direct payment from USAC.[22] Any unfunded shortfall, by law, may be claimed as a credit against the service provider's contribution obligation. In effect, USAC is robbing Peter to pay Paul.

2. Full Telecom Program Funding Is Vital for Alaska

The record reflects urgent telehealth and telemedicine needs that the Commission should meet immediately for Funding Year 2017 and beyond. Since the FCC created the RHC support mechanism in 1997, the challenges of healthcare in rural America have grown steadily. Today, rural Americans, on average, are older than their urban counterparts[23] and sicker than their urban counterparts,[24] have

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22 47 U.S.C. § 254(h)(1)(A).

23 *See, e.g.,* American Ass'n of Orthopaedic Surgeons ("AAOS") Comments at 2.

24 *See, e.g.*, Policy Brief, "Mortality and Life Expectancy in Rural America: Connecting the Health and Human Service Safety Nets to Improve Health Outcomes over the Life Course," Oct. 2015 (Health Resources and Services Administration, National Advisory Committee on Rural Health & Human Services) ("*HRSA Mortality Brief*"), at 4 ("rural America is older,

access to fewer doctors *per capita* than their urban counterparts,[25] and have a lower life expectancy than their urban counterparts.[26] In recent years, the epidemic of opioid addiction and dependency has become a public health crisis,[27] again disproportionately affecting residents of rural areas.[28]

Significantly for purposes of the RHC program budget, healthcare costs nationwide continue to increase at a greater pace than general inflation.[29] The record in this proceeding

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poorer, and sicker than urban America"), available at: https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2015-mortality.pdf

25 SHLB Comments at 2.

26 *HRSA Mortality Brief* at 2 (while life expectancy at birth has generally increased for over a century, urban-rural disparities in mortality and life expectancy have been increasing in recent decades, with some rural areas seeing actual declines in life expectancy); Science Daily, "Gap in Life Expectancy between Rural, Urban Residents is Growing," Jan. 23, 2014 (while overall life expectancy in the US increased from 70.8 years in 1970 to 78.7 years in 2010, the urban-rural life expectancy "gap" grew from 0.4 years to 2.0 years over the same period), available at: https://www.sciencedaily.com/releases/2014/01/140123154752.htm.

27 *See, e.g.,* Andrew Sullivan, "The Poison We Pick," *New York Magazine*, Feb. 19, 2018 ("More than 2 million Americans are now hooked on some kind of opioid, and drug overdoses — from heroin and fentanyl in particular — claimed more American lives last year than were lost in the entire Vietnam War. Overdose deaths are higher than in the peak year of AIDS and far higher than fatalities from car crashes. [Opioids have] now been responsible for a decline in life spans in America for two years in a row, a decline that isn't happening in any other developed nation. According to the best estimates, opioids will kill another 52,000 Americans this year alone — and up to half a million in the next decade"), *available at:* http://nymag.com/daily/intelligencer/2018/02/americas-opioid-epidemic.html.

28 *See, e.g.,* AAOS Comments at 2; CHIME Comments at 2 (citing CDC data showing that opioid misuse and related deaths are higher among poor and rural populations); NHeLP Comments at 7-8 (same); Policy Brief, "Families in Crisis: The Human Service Implications of Rural Opioid Misuse," July 2016 (Health Resources and Services Administration, National Advisory Committee on Rural Health & Human Services) ("*HRSA Opioid Brief*"), at 2-3 (observing that drug-related deaths are 45% higher in rural areas, with opioid-related overdose deaths in rural areas increasing exponentially in recent years; and that the challenges of treating opioid abuse are greater in rural areas, given the limited health and social service infrastructure available), *available at:* https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2016-opioid-abuse.pdf.

29 Franciscan Health Alliance/Parkview Health System ("FHA/PHS") Comments at 7-8. In 2016, healthcare spending grew to $10,348 per person and 17.9% of GDP, *id.* at 9.

provides overwhelming evidence that RHC funding can be a crucial tool in helping to control these costs in areas that are disproportionately affected – rural America. By reducing healthcare costs and increasing diagnostic and treatment options,[30] RHC support for telehealth yields substantial dividends in patient outcomes as well as cost reductions. But the budget for this program must be expanded to meet demand; otherwise the challenges of providing modern healthcare services in rural areas will overwhelm available resources.

These challenges are particularly acute in Alaska.[31] The state's unique geography, topography, climate, and size mean that rural Alaskans are profoundly isolated from the infrastructure of daily life that most Americans take for granted. In many cases, they lack not only connections to national road transportation networks, and state and regional power grids, but also access to basic healthcare resources. Fewer than half of the state's residents, but over three-quarters of the state's doctors, live in Anchorage and Fairbanks.[32] Well over one hundred

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30 *See* HIMSS/PCHAlliance Comments at 3 (discussing "Hospital at Home" program and citing Bruce Leff, M.D., "Why I Believe in Hospital at Home," *NEJM Catalyst*, Feb. 5, 2017, which reports that the program "resulted in fewer complications (e.g., drastic reductions in delirium), greater satisfaction with care for patients and family members, less caregiver stress, better functional outcomes, *and lower costs*") (emphasis added); Chugachmiut Comments at 2 (telemedicine helps "reduce travel and Medicaid costs"); Alaska Native Tribal Health Consortium Comments at 5 (explaining that "[m]ore than 70 percent of all consultations using these tools prevent the patient from having to travel to see a specialist – resulting in statewide savings estimated at $10 million annually in avoided patient travel costs"); Alaska State Hospital and Nursing Home Ass'n Comments at 2 (same); Maniilaq Comments at 3-4 (same); Alaska Native Health Board Comments at 4 (same); AK Child & Family Comments at 2 (same); Cross Road Health Ministries Comments at 1 (same); South Peninsula Hospital Comments at 3 (citing record storage cost savings and evidence that, "that access to telehealth services also lowers health care costs in rural communities, saving money at the local, state and national levels").

31 Alaska Native Health Board Comments at 5 (stating that, because of "limited infrastructure, extreme geographic isolation, limited historic investment in utilities and communications systems, and very high travel, fuel, and health care costs, Alaska stands out as a unique example of the rural–urban divide the RHC was intended to address").

32 *See* GCI Comments at 5, 7.

communities, many of them home primarily to Alaska Natives, are scattered across the state's vast wilderness, with populations ranging from a few dozen to a few thousand people. Many of these communities lack even a single doctor, let alone medical specialists or equipment that support the modern standard of care across most of the rest of the nation.[33]

These factors conspire to make rural Alaskans more dependent on telemedicine services than any other group of Americans. A myriad of Alaskan healthcare providers, rural hospitals, Tribal governments and councils, and service providers have offered comments attesting to the transformative effects of telemedicine supported by the FCC's RHC support mechanism over the past two decades in the state. From Alaska's Community Health Aides/Practitioners ("CHA/Ps") and the Alaska Federal Health Care Access Network ("AFHCAN") telemedicine cart,[34] to remote telestroke, eICU, X-ray, CT, MRI, mammography, ultrasound, and DEXA scans,[35] to cost-saving medical videoconferencing services,[36] telemedicine in Alaska is crucial to delivering modern health care to rural and remote communities across Alaska.[37] Without it,

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33 *See, e.g.,* USTelecom Comments at 9; NHeLP Comments at 5; American Hospital Ass'n Comments at 2.

34 GCI Comments at 8-9.

35 South Peninsula Hospital at 2; Central Peninsula Hospital at 2.

36 Alaska Native Health Board at 4 (explaining that the Alaska Native Medical Center now offers 30 different specialties by video conferencing, with more than 70% of all consultations using these tools prevent the patient from having to travel to see a specialist).

37 Maniilaq Comments at 3 (the Alaska Tribal Health System delivers care at more than 200 facilities throughout Alaska and has been used by 4,500 providers for more than 300,000 clinical cases, generating almost 70,000 EKGs of heart patients, 200,000 images of ear disease alone, and another half million images of trauma, wounds, and rashes; approximately 20% of all Alaska Natives receive care through telehealth, a level of adoption unmatched anywhere else in the Unites States); Southcentral Foundation at 1 (telemedicine essential to caring for 65,000 Alaska Native and American Indian people spread over 100,000 square miles).

access to regular physicals, management of chronic conditions, and emergency care for injuries, heart attacks, strokes, and a host of other conditions, all would be severely curtailed.

Moreover, RHC support directed to Alaskan HCPs disproportionately (and appropriately) benefits Tribal populations.[38] Full funding for the Telecom Program therefore would be in accord with the FCC's commitment to, among other things, "promote the deployment and adoption of communication services and technologies within Native communities and on Tribal lands . . . , to develop and implement policies for assisting Native communities; and ensur[e] that Native concerns and voices are considered in all relevant Commission proceedings and initiatives."[39] Today, fully twenty percent of Alaska Natives receive healthcare via telehealth services, with more than 300,000 clinical cases handled to date through the Alaska Tribal Health System.[40] Quite simply, failure to fully fund the Telecom Program is a failure to promote the availability of telehealth services and technologies in Tribal communities.

3. Asking Service Providers to Absorb the Shortfall Is Not a Solution

In the *Order*, the Commission permitted service providers – for the second consecutive year in Alaska – to "voluntarily" waive collection from their customers of the Telecom Program funding shortfall necessitated by the Commission's self-imposed budget constraints. As multiple commenters have made clear (and as should be self-evident in any case), this cannot be a long-term solution.[41] This budgetary crunch is entirely of the Commission's own making and, far from

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38 ANTHC Comments at 1-3, 5-6; Am. Hosp. Assn. Comments at 10-11; Bristol Bay Area Health Corp. Comments at 3-4; Maniilaq Comments at 2; Norton Sound Comments at 3.

39 *Establishment of the Office of Native Affairs and Policy in the Consumer and Governmental Affairs Bureau*, Order, FCC 10-141, 25 FCC Rcd 11104, at ¶ 1. *See* ANTHC Comments at 1-3, 5-6; Amer. Hospital Ass'n Comments at 10-11; Bristol Bay Area Health Corp. Comments at 3-4; Norton Sound Comments at 3; Maniilaq Comments at 2.

40 ANTHC Comment at 5.

41 *E.g.,* USTelecom Comments at 10-11; GCI Comments at 41.

being compelled by the statute, contravenes the statute's mandate to fully fund the urban-rural difference for rural telehealth services demanded under the Telecom Program, as discussed above.

Service providers incur real costs to provide service – operating expenses and overheads, depreciation, return on their capital investments, as well as payments to third parties for wholesale services necessary to extend the reach of their own networks – and must, in general, charge rural rates that reflect those paid by unsubsidized commercial customers or the tariffed or publicly available rates of other providers.[42] By both pro-rating support amounts and undermining what little opportunity the service provider may have to seek payment of the shortfall from the customer, the Commission impairs the ability of the service provider to recover its costs, and creates severe economic disincentives to participate in the program at all.[43] Furthermore, the Commission's order threatens to distort the competitive bidding process, creating the risk that HCPs will take a service provider's willingness to forego recovery of the funding shortfall into account when evaluating its bid.[44] Healthcare providers supporting the Commission's action[45] shortsightedly fail to recognize the threat it represents to the very fabric of the RHC support mechanism.

As a result, the Commission should take immediate action, beyond the "rollover" of unused RHC support funds, to fully meet demand for Funding Year 2017 and beyond. The current $400

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42 47 C.F.R. § 54.607(a-b).

43 *See Ex Parte* Letter from Kevin G. Rupy, USTelecom, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 7, 2017).

44 USTelecom Comments at 11; Maniilaq Comments at 6; Alaska Native Health Board Comments at 6.

45 Connected Health Initiative Comments at 5; Southcentral Foundation at 4; Council of Athabascan Tribal Governments at 6.

million budget, set over 20 years ago, is no longer sufficient to meet the health challenges of rural America and the needs of modern telehealth and telemedicine equipment and services.

B. If the Commission Retains a Cap on RHC Support, The Record Confirms that the Budget Should Be At Least Doubled

For the reasons discussed above, the Commission should – and must – exempt the RHC Telecom Program from any cap on support. If the Commission nevertheless decides to retain a budget cap in place, the record demonstrates that it should increase the cap to $800 million or more.

For all of the many reasons explained in the record, Alaska Communications concurs with SHLB that "doubling the $400 million cap to $800 million is justified."[46] This is true, whether the Commission examines the issue from a "top down" perspective (*i.e.,* examining inflation and other factors that necessitate adjustment of the current budget) or a "bottom up" perspective (*i.e.*, assessing current need without regard for the Commission's previous budget decisions).

From a "top down" perspective, the record reflects a host of factors that the Commission should consider in adjusting the RHC budget upward. First and foremost, two decades of inflation have eroded the purchasing power of the original $400 million figure. While there are many ways of assessing inflation, the record reflects that this adjustment alone would increase the budget by approximately 50 percent.[47] Alaska Communications believes emphatically that,

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[46] SHLB Comments at 3; *see also* Council of Athabascan Tribal Governments Comments at 6 ("if the FCC keeps any cap in place, the base level of funding for the RHC Program be doubled to $800 million at a minimum. Additionally, the RHC Program should be adjusted in the future to account for inflation, which is, for instance, how the E-Rate Program operates."); CHiME Comments at 2.

[47] Many commenters cite the Commission's calculation that, using the GDP-CPI as a measure of inflation, the equivalent budget would be $571 million today. *See, e.g.,* GCI Comments at 18, American Hospital Ass'n at 9, American Academy of Family Physicians at 1, California Hospital Ass'n at 2. Other commenters have shown that other measures of inflation would produce an equivalent budget between $600 million and $810 million. *E.g.,* FHA/PHS Comments at 5-6 (adjusting the budget for CPI-U yields an inflation adjusted budget of

no matter which metric the Commission uses, the Commission should update the budget to reflect the effects of inflation over this long period of time, and index the budget for automatic annual adjustments on a going-forward basis.

As many commenters point out, however, mere adjustment for inflation is an incomplete answer.[48] Transformative changes in telehealth and telemedicine, coupled with changes to the RHC support mechanism itself, have increased the need for funding, both to meet the statutory command of the Telecom Program, and to implement the policy goals of the HCF. Among other factors cited in the record:

- The statutory change making not-for-profit skilled nursing facilities eligible for support has substantially expanded the pool of applicants;[49]
- Technological advances have dramatically expanded the range of medical services that can be delivered remotely and raised the standard of medical care, driving the need for increased bandwidth to enable, for example, real-time, interactive videoconferencing and monitoring that were not needed in 1997;[50]

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roughly $620 million, while the CPI-Medical yields an adjusted budget of $810 million); Alaska Communications Comments at 11-12 (showing inflation adjustments yielding a budget of roughly $600 million).

48 *E.g.,* GCI Comments at 20 (pointing out that "merely updating the cap to account for twenty years' worth of inflation is an incomplete and insufficient solution to this problem"); National Ass'n of Community Health Centers Comments at 2, 16 (arguing that, "[i]n future years, the funding cap should be to reflect inflation, eligibility expansions, and changes in costs resulting from advances in technology"); AK Child & Family Comments at 1 (asserting that, "the FCC should increase the budget for the rural health care support mechanisms to reflect inflation over the past two decades and increases in the level of support available from those mechanisms, as well as increased technology and telecommunications demands due to our HIPAA legal obligations, advances in telemedicine capabilities, changes in patient expectations and standards of care, and new demands from skilled nursing facilities"); Alaska Tribal Administrator's Ass'n Comments at 1 (same); American Telemedicine Ass'n Comments at 2.

49 SHLB Comments at 13 (estimating that there are some 4,675 such facilities nationwide); ADS Comments at 2 ("It is important to consider the increasing number of eligible beneficiaries (like skilled nursing facilities)").

50 *See, e.g.,* HIMSS/PCHAlliance Comments at 4 ("[W]hen the Fund was first established, broadband connectivity was used primarily for electronic administrative functions, radiology,

- HIPAA patient privacy and Electronic Health Records initiatives have increased demand for cloud-based services enabled by secure, reliable packet-switched data connections;[51]

- Changes to the RHC support mechanism have expanded the range of services, equipment, and HCPs that are eligible for support, as well as the level of that support.[52]

Taken together, these developments have driven demand for rural healthcare support steadily higher for the past twenty years. The Commission's budget should be adjusted, and continue to adjust, accordingly, not just for inflation, but for foreseeable increases in the demand for funding

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and limited amounts of telehealth. Today, broadband connectivity is an evidence-based component of chronic care management and routine care delivery."); ADTRAN at 4 ("ADTRAN agrees that broadband connectivity has become even more critical as remote healthcare has grown in importance and sophistication. Diagnoses, consultations and education for healthcare practitioners and patients in rural areas can greatly enhance patient outcomes, and all of those activities have grown more sophisticated since the Commission adopted the RHC program . . . . Finally, advances in robotics are making remote surgery possible. All of these activities require highly reliable, high-speed and low-latency broadband services connecting healthcare facilities in rural areas"); ADS Comments at 2 (critical factors in increasing demand include "advances in technology (such as technology centric Telehealth options, including home based services, as well as many other initiatives based on technology and cloud-based services)").

[51] *See, e.g.,* FHA/PHS Comments at 5-6, 14-15 (network security is of increasing importance to rural HCPs, with the cost of data breaches skyrocketing); TeleQuality Comments at 21 (HCPs increasingly consider network reliability, security and service levels to be critical aspects of their telehealth services and infrastructure); SHLB Comments at 7; ADTRAN at 4 ("In addition, the federal government has mandated the use of electronic health records, and sharing of that information can improve healthcare results").

[52] For example, under the HCF, non-rural HCPs may receive support as members of consortia, a larger range of network equipment and services are eligible for support, upfront and construction costs are now eligible, and the level of support for Internet access services has increased from 25 percent to 65 percent of the monthly charges, *see Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order and Further Notice of Proposed Rulemaking, FCC 12-150, 27 FCC Rcd 16678 (2012) (*Healthcare Connect Fund Order*"), at ¶¶ 45, 91.

necessary to keep evolving telemedicine services and standards of care affordable for rural Americans and rural HCPs alike.[53]

From a "ground up" perspective, SHLB has placed in the record an insightful update to the Commission's previous demand estimates. In 1997, the Commission settled on a $400 million budget based on its estimate of the demand for support if every eligible rural health care provider in the nation purchased a single T-1 line.[54] In 2012, the Commission reexamined that calculation in connection with its creation of the HCF, and found no change was warranted.[55] SHLB's new calculations show that there are more than twice as many eligible rural HCPs today as the Commission identified on either of those previous occasions.[56] If all of them were to receive the average amount of Telecom Program support that the Commission issues to an applicant today ($32,000), the RHC support mechanism budget would need to be at least $833 million.[57]

The need for adequate support is great, and the Commission's universal service support mechanisms are powerful tools for driving growth and improvement. In 2014, the Commission adopted a pair of Orders modernizing the E-rate program, in which it: (1) adopted the State

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53 *See, e.g.,* ANTHC Comments at 8 (arguing that, in addition to adjustment for inflation, "the RHC program also needs to be adjusted in the future for growth in connectivity demand for health care: modern applications such as videoconferencing continue to drive the need for higher bandwidth and lower latency, and the mission-critical nature of telecommunications is driving the need for redundant and more fault tolerant systems"); GCI Comments at 2 (arguing that the Commission should "establish a mechanism to self-adjust annually going forward, both for inflation and to accommodate the growing importance of telemedicine in rural healthcare").

54 *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, FCC 97-157, 11 FCC Rcd 8776 (1997) ("*First Universal Service Order*"), at ¶¶ 705-08 (subsequent history omitted).

55 *Healthcare Connect Fund Order* at ¶ 98.

56 SHLB Comments at 13 (documenting more than 26,000 eligible HCPs, compared to the Commission's previous estimates of 10,000-12,000).

57 *Id.* at 14.

Education Technology Directors Association's recommendation to establish Internet access bandwidth goals for schools of at least 100 Mbps per 1,000 students and staff (users) in the short term and 1 Gbps Internet access per 1,000 users in the longer term;[58] and (2) raised the budget cap on the E-rate mechanism to $3.9 billion, indexed for inflation.[59] Today, only three years later, the record reflects that 94 percent of schools meet the minimum federal connectivity target.[60]

In contrast, rural healthcare providers remain substantially underserved, struggling to improve care and implement modern telemedicine services with a support budget that is less than one-tenth that available under the E-rate mechanism.[61] It is past time for the Commission to seek the same transformative change in rural health care, and to make the necessary resources available, that it created with E-rate.

C. The FCC Should Make Permanent the Annual "Rollover" of Unused Prior Year's Funds

In the *Order*, the Commission directed USAC to commit any unused funds carried forward from prior years to the RHC Program funding for FY 2017 to lower or eliminate the proration factor, first for all qualifying funding requests from non-consortia rural healthcare providers, and then, if there are funds remaining, for qualifying funding requests from consortia.[62]

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58 *Modernizing the E-rate Program for Schools and Libraries*, WC Docket No. 13-184, Report and Order and Further Notice of Proposed Rulemaking, FCC 14-99, 29 FCC Rcd 8870 (2014) ("*E-rate Modernization Order*") at ¶ 34.

59 *Id.* at ¶ 114.

60 FHA/PHS Comments at 9.

61 CHiME Comments at 2 (citing lack of affordable broadband access as a barrier to deployment of health information technology and telehealth services); OCHIN Comments at 2 ("[E]very week we are presented with situations that indicate there is still much work to be done . . . . [W]e continue to seek viable solutions to provide reliable broadband to support hosted EHR and live video consultations over broadband to communities that are isolated from major medical centers.").

62 *Order* at ¶ 109.

Alaska Communications agrees with the many commenters in the record that support making this practice permanent for future years as well.[63] The Commission should pursue every reasonable opportunity to ensure sufficient funding for the RHC mechanism, as Alaska Communications argued last year, when the Commission directed USAC to spend a full $100 million in such unused RHC funds to create a small, ephemeral reduction in the contribution factor for one calendar quarter, instead of carrying it forward to meet future rural healthcare needs.[64] Alaska Communications also agrees that the carry-forward process "must not be allowed to slow down the approval of the next immediate funding year's" decisions.[65] USAC's funding decisions are already severely delayed, and must be speeded up, not further hampered by calculation of the amount of carry-forward funding available.

When using any such carry-forward funds, the record generally supports prioritizing individual applicants over consortia. First and foremost, the statute requires that the Telecom Program be fully funded, as discussed above. HCPs applying for support under the Telecom Program therefore should receive highest priority for any available funds, including those carried over from prior years,[66] and the majority of Telecom Program applicants are individual HCPs,

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63 *See, e.g.,* Kellogg & Sovereign Comments at 6; American Hospital Association Comments at 9; TeleQuality Comments at 7; Illinois Rural HealthNet Comments at 2; FHA/PHS Comments at 8. While FHA/PHS suggests that the rollover include funds previously held in reserve for appeals, Alaska Communications cautions that the USAC should continue to hold such funds in reserve until the resolution of the underlying appeal has become final, *i.e.,* until a decision granting or denying the appeal has been published by USAC, the Wireline Competition Bureau, or the full Commission, as the case may be, and the period for requesting reconsideration or appeal of any denial has expired without the filing of any such request.

64 *Ex Parte* Letter of Karen Brinkmann, Counsel to Alaska Communications, WC Docket No. 02-60 (filed June 9, 2017), at 5-6.

65 Illinois Rural HealthNet Comments at 2.

66 *See, e.g.,* SHLB Comments at 24 (proposing to exclude Telecom Program applicants from any *pro rata* support reductions).

not consortia. Second, the most significant objection to prioritizing individual HCPS reflected in the record is that it would increase the "administrative complexity" of the funding process.[67] But, the Commission has already ordered USAC to proceed on this basis for Funding Year 2017. USAC will therefore already have developed the necessary administrative processes to implement such prioritization in future years.

II. The Record Confirms that the Commission Should Overhaul Its Rules Governing the Calculation of Urban and Rural Rates.

The record in this proceeding confirms what has been obvious from USAC's protracted reviews and delay in announcing decisions on funding requests for Funding Years 2016 and 2017: The Telecom Program's urban and rural rate rules have been overtaken by profound changes in the market for telecommunications transport services since 1997, and no longer serve their purpose. These outdated rules now are impeding the approval of support for telecommunications services that are necessary for the provision of healthcare services in rural America.

As discussed below, Alaska Communications agrees with the many commenters that advocate reliance primarily on market forces and the competitive bidding process to determine the rural rates supported under the Telecom Program, with certain regulatory safeguards to ensure that rural rates are not reimbursed at above-market levels: (1) a "Lowest Corresponding Price" rule modeled on the E-rate program; (2) a cap on support for terrestrial rates that exceed those for functionally similar satellite services; and (3) increased transparency through additional public disclosure by USAC of supported rates and services, as a safeguard to deter waste, fraud, and abuse in the RHC support mechanism. Alaska Communications believes that the record

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[67] *See, e.g.,* Western New York Rural Broadband Healthcare Network Comments at 2; Kellogg & Sovereign Comments at 6-7.

supports the conclusion that these safeguards offer sufficient deterrence to waste, fraud, and abuse in the market for packet-switched transport services that is growing ever more competitive.

A. The Commission Should Adopt Safeguards Against Abusive and Noncompetitive Rates

1. The Commission Should Adopt a "Lowest Corresponding Price" Rule for the RHC Support Mechanism

The record supports adoption of a "Lowest Corresponding Price" rule for the RHC support mechanism.[68] The Lowest Corresponding Price rule requires service providers to offer schools and libraries participating in the E-rate support mechanism the "the lowest price that a service provider charges to non-residential customers who are similarly situated to a particular school, library, or library consortium for similar services."[69] Alaska Communications readily acknowledges that this rule, rooted in archaic concepts of "similar services" and "similarly situated" that were never easy to apply, even in the days of tariffed offerings from dominant carriers, Alaska Communications believes that it would be less burdensome than other alternatives. With appropriate guidance from the Commission, it cabins USAC's authority to engage in second-guessing rural rates in areas with few market participants and, indeed, few customers (typical of the areas supported by the RHC program).

The Commission revisited the Lowest Corresponding Price rule as recently as 2014, and codified it in a form that requires service providers both to submit bids to E-rate applicants that offer prices no higher than the lowest price they charge to similarly-situated nonresidential customers for similar services, and to actually charge such applicants that price.[70] This

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[68] GCI Comments at 31; Alaska Communications comments at 26.

[69] 47 C.F.R. §§ 54.500 (definition), 54.511(b) (establishing right of E-rate applicants).

[70] *E-rate Modernization Order* at ¶ 185.

implementation, the Commission found, provided clear standards that could be enforced by the Enforcement Bureau, even though the pricing of Internet access and internal connections – involving products and services that are not otherwise price-regulated by the Commission – present more difficult cases than telecommunications services supported by the Telecom Program.[71]

The record shows that the Lowest Corresponding Price rule could provide a standard that would deter excessive rates under the RHC support mechanism as well, while eliminating the need to identify a pinpoint "average," as today's "rural rate" rules seem to contemplate. The Commission has found that this rule "benefits E-rate applicants and the Fund by ensuring that the price for E-rate supported services is no more than the market price for those services, absent a showing by a provider that it faces demonstrably higher costs to serve a particular school or library."[72] That is an equally worthy goal for the Commission's modernization of the RHC support mechanism. And, as GCI has explained, a rate meeting the strictures of the Lowest Corresponding Price rule for E-rate purposes would achieve the goal, because the Lowest Corresponding Price objectively provides "an indicator of the reasonableness of a carrier's rate charged to a rural healthcare provider for a supported service."[73] Thus, Alaska Communications continues to support adoption of a Lowest Corresponding Price rule as a primary tool for governing rates supported under the RHC support mechanism.

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71 *E-rate Modernization Order* at ¶ 184, n.424 (citing decision in the *Universal Service First Report and Order* that the Lowest Corresponding Price rule applies to providers of telecommunications services, Internet access and internal connections).

72 *E-rate Modernization Order* at ¶ 184.

73 GCI Comments at 31.

2. The Commission Should Cap Support Based on the Lower of the Rate for Functionally-Similar Terrestrial or Satellite Service, Where Both Are Available

In western Alaska, where the terrestrial transport network is under the monopoly control of a single provider, there is a profound lack of competition to serve schools, libraries, and rural health care providers. In that environment, Alaska Communications has argued that the Commission must adopt an additional safeguard against wasteful and abusive rates supported by the RHC support mechanism by capping support based on the *lower of* the rate for functionally similar satellite-delivered or terrestrial services, where both are available. GCI's objections notwithstanding, the record supports adoption of such a rule.

GCI's argues for the Commission to base Telecom Program support on rural rates set by unfettered competition, not constrained by any regulatory pricing constraints,[74] and, as discussed below, Alaska Communications largely agrees. However, large areas of western Alaska neither have meaningful facilities-based competition to constrain prices, nor are subject to state or federal regulatory constraints on rates for long-haul (middle mile) services necessary to link those areas to the rest of the state and the nation. Indeed, in areas served by the TERRA monopoly terrestrial transport network, GCI has captured the lion's share of the subsidies for services to schools, libraries, and rural healthcare providers.[75] This is so, despite the fact that

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[74] GCI Comments at 28.

[75] *See Ex Parte* Letter from Richard R. Cameron for Alaska Communications, CC Docket No. 02-60 (filed Nov. 13, 2017) ("*Alaska Communications Nov. 13, 2017 Ex Parte*"), at 3 (showing that GCI receives approximately $67 million in rural health care support committed to HCPs in communities served by TERRA, representing 96.8 percent of the total support committed to the area). While GCI asserts that TERRA serves "commercial and governmental enterprises (sold on both a retail and wholesale basis to other carriers)," GCI Comments at 32, quantities are tiny compared to E-rate and RHC customers. Alaska Communications, for example, purchases a single 1 Mbps connection on TERRA for resale to its own RHC customer, meaning that our purchase, too, is supported by the Telecom

rates on TERRA are the most expensive in the nation. GCI's published rates show that TERRA prices can exceed $8,000 per Mbps,[76] far above the prevailing rates for functionally similar satellite service in the same area.[77]

In such an environment, it is plain that additional safeguards are needed. While GCI argues that terrestrial services offer superior performance to satellite, it offers no evidence that the premium it charges RHC providers is justified. For example, while GCI states that it "incurred more than $178 million in risk for the capital necessary to build TERRA,"[78] it fails to explain what that unusual linguistic formulation actually means in terms of unsubsidized capital expenditures on facilities actually deployed in the service of RHC projects, or how that "risk" has impacted its rates.

GCI's argument that a cap on support for terrestrial rates based on functionally similar satellite services would be "arbitrary and capricious" is equally unavailing. While GCI argues that "[s]atellite is not an appropriate comparison when low-latency, high-quality services are needed,"[79] [it is plain that low latency is not a requirement for *all* applications, such as those that

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Program, with virtually the entire profit flowing back to GCI, despite Alaska Communications appearing in the funding request as the nominal service provider.

[76] *See* GCI, "TERRA Product Descriptions and Pricing," eff. July 1, 2017, at 4 ("2017 TERRA Pricing") (showing monthly recurring charges for quantities of 1-100 Mbps, on a month-to-month basis, to points located in a "Regional Center" of $864 per 1 Mbps (Hub Port) and $7,344 per 1 Mbps (Edge Port), for a total of $8,208 per month per 1 Mbps service) (available at: https://www.gci.com/-/media/files/gci/regulatory/gci_terra_posting_effective_070117.pdf); *Alaska Communications Nov. 13, 2017 Ex Parte* at 2, n.2.

[77] National Telecommunications and Information Administration, *Telecommunications Assessment of the Arctic Region*, Docket #140925800-4800-01, Notice of Inquiry, Submission of Quintillion Networks (Dec. 2014), at 1 (*available at:* https://www.ntia.doc.gov/files/ntia/quintillion_12022014.pdf) (observing that, in Alaska, "[c]arrier-to-carrier prices on satellite range from $1,400 to $4,000 per Mbps per month").

[78] GCI Comments at 14, n.25.

[79] GCI Comments at 31.

do not require real-time, two-way interactive communication, such as image and data transfers, electronic health record storage and retrieval, and the like. Indeed, many HCPs, including many in Alaska, continue to rely on satellite-based services to meet many of their needs.[80]

Platform differences, without more, do not determine whether satellite and terrestrial services are "functionally similar." Indeed, the Commission's current rule capping the support available for more-expensive satellite services where less-expensive terrestrial alternatives are available is founded on the premise that satellite services *can be* functionally similar to their terrestrial alternatives for many applications.[81] Ethernet over TERRA is still just Ethernet, and offers no greater functionality than Ethernet over satellite (aside from lower latency for the portion of usage devoted to real-time, interactive applications). And, multiprotocol label switching ("MPLS") offers superior network security and patient privacy to Ethernet (at greater cost), whether offered over terrestrial or satellite facilities.

GCI's argument that making this rule symmetrical would be "administratively complex" is unavailing.[82] It would be no more administratively complex than the current rule, which already requires comparison of satellite and terrestrial rates in cases to which the rule applies.

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[80] *E.g.,* Southcentral Foundation Comments at 1 ("In the villages we serve, we rely on satellite transmission circuits to ensure our patients get the best care possible. Our clinical staff, the primary care doctors and specialty doctors can now see in real time what is being entered into the patients' medical records. This has greatly improved medication management, reduced hospital re-admittance, and increased patient safety.").

[81] *See* 47 C.F.R. § 54.609(d)(1) ("Support for satellite services shall be capped at the amount the rural health care provider would have received if [it] purchased a *functionally similar terrestrial-based alternative*.") (emphasis added); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, FCC 03-288, 18 FCC Rcd 24546 (2003), at ¶ 44 (holding that, "discounts for satellite services even where alternative terrestrial-based services may be available . . . . will be capped at the amount [healthcare] providers would have received if they purchased *functionally similar terrestrial-based alternatives*") (emphasis added).

[82] GCI Comments at 30-31.

A cap on support for terrestrial service in western Alaska will give HCPs there well-designed pricing signals to inform their choices, and more "skin in the game." For many applications, terrestrial service in western Alaska is "nice to have" but not essential. GCI offers examples of how telemedicine has cut diagnosis and treatment times by "three to four days" compared to transmission of X-rays and other medical image files by physical mail.[83] But transmission and reading of X-rays does not involve real-time interactive activities, and latency delays over GSO satellites are less than one second. Thus, some satellite-based services can be as effective for many telemedicine or telehealth applications. For example, Southcentral Foundation, an Alaska Native Tribal health organization that serves over 65,000 Alaska Native and American Indian people, including 13,000 residents in 55 rural Alaska villages, states that, "we rely on satellite transmission circuits to ensure our patients get the best care possible."[84] The Commission thus need not and should not divert scarce funds from other needy HCPs to subsidize an exorbitant and unjustified premium for unlimited terrestrial services in western Alaska

The need for a constraint on TERRA rates in western Alaska is particularly great, in order to halt GCI's apparent cross subsidization of distant construction projects with RHC support. In its comments, GCI admits as much, stating that it "put one of its proposed fiber builds—to Unalaska, a highly remote town in the Aleutian Islands—on hold as a result of the uncertainty created by the present proceeding."[85] Although, the proposed fiber does not yet exist, and

[83] GCI Comments at 11.

[84] Southcentral Foundation Comments at 1.

[85] GCI Comments at 39, n.86.

therefore could not be directly supported by the customers it would reach, uncertainty of *current* funding has apparently impacted GCI's plans.[86]

Alaska Communications also disagrees with SpaceX's argument that the Commission should eliminate Section 54.609(d) of its rules in favor of a proposal to use an average of all publicly-available rates (including those for satellite service) to determine the rural rate for a given area.[87] This proposal makes no sense. *First*, in most areas, where rates for GSO satellite services far exceed those for terrestrial services, such a rule would provide a substantial, unjustified windfall to terrestrial service providers. Second, in western Alaska, where terrestrial rates far exceed those for GSO satellite services, an average would not effectively rein in excessive terrestrial pricing. In short, SpaceX offers no justification for providing unbounded support for the most expensive technology where more cost-effective substitutes are available. To the contrary, as USTelecom points out, "[b]y capping rates for [terrestrial] services based on the cost of functionally similar satellite alternatives, the Commission could eliminate tens of millions of dollars annually in wasteful spending under the Telecom Program with this one change alone."[88]

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86 *See also* GCI Comments at 15 (highlighting GCI's cross-subsidization of non-RHC services with RHC support in stating that, "[t]hrough USF support, rural healthcare facilities not only bring much-needed medical services to rural areas, but also help to justify the terrestrial broadband infrastructure investment that benefits the regions' non-medical institutions, government, public safety, rural residents, and small businesses. In addition to improved healthcare, the RHC Program-supported expansion of broadband communications options to residents in Alaska's vast wilderness areas enhances regional economic development, economic opportunities, and education.").

87 *See, e.g.,* SpaceX Comments at 5-6.

88 USTelecom Comments at 17.

3. The Record Supports Publication of Data on Rural Rates and Services Supported by the RHC Support Mechanism

The record reflects broad support for public disclosure of the pricing data for services supported by RHC support mechanism, akin to changes that have been in place for the E-rate support mechanism for several years. In 2014, the Commission amended its E-rate rules to require such disclosure, finding that pricing transparency would, "improve analyses performed by the Commission, state coordinators, and third parties regarding the program's effectiveness and whether more needs to be done to improve cost-efficient purchasing by schools and libraries" and "help third parties identify best practices for purchasing and reduce waste across the program."[89]

Alaska Communications agrees with the many commenters that support adoption of this change for the RHC support mechanism as well.[90] As ADS observes, "[t]ransparency is important from a services perspective, a beneficiary's participation perspective, and the Administrator's decision making perspective."[91] Today, USAC publishes only the amount of support it commits to a given HCP, but not the quantity or type of services for which it received that support, nor the rural rate it approved. Nor does USAC publish any information about unsuccessful bids. Greater transparency and access to more complete bid information will serve as an effective and independent check on rural rates, send clearer signals to the market about appropriate pricing for particular services, and produce lower overall costs and deterring fraud

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89 *E-rate Modernization Order* at ¶ 159.

90 *See* SHLB Comments at 34; USTelecom Comments at 15; Kellogg & Sovereign Comments at 18; *Ex parte* Letter from Raquel Noreiga, AT&T, WC Docket No. 17-310 (filed Jan 25, 2018), at 1.

91 ADS Comments at 1.

and abuse.[92] As ADS explains, "[w]ith respect to the [Schools and Libraries Division] and E-rate, pricing information is made public and is not considered confidential. ADS believes this was done to promote competition and drive pricing down. Perhaps something similar can be done in the RHCP."[93] This could be readily accomplished by requiring service providers to submit bids through central bid registry or portal, that would offer an opportunity for vendors to copy USAC when submitting a bid to an applicant.[94]

By making public a nationwide database of rural rates and services, USAC could streamline the compliance process, even as it makes it more effective. As SpaceX explains, "a USAC database of rural and urban rate data, based on public sources, will eventually make it faster and easier for applicants to show that their proposed rates are representative of what would be charged for a service in the area."[95] Alaska Communications believes that such a database could most readily be compiled from successful funding requests, particularly given that the FCC Forms 462 and 466 already alert users on their face: "Information requested by this form will be available for public inspection." Today, Kellogg & Sovereign argue, the "RHC program only provides 'lip service' to the FCC's requirement for program transparency."[96] Alaska Communications agrees that it is past time for the FCC and USAC to share the information

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92 TeleQuality Comments at 19 ("Had the bad actions of NSS and DataConnex occurred in the E-rate Program, they likely would have been spotted by competitors, who would have complained to the applicants and to USAC"); ADS Comments at 2 ("All RHCP data should be available to the public (such as the Schools and Libraries Division ('SLD') Data Retrieval Tool), allowing better understanding of the data").

93 ADS Advanced Data Services Comments at 3.

94 SHLB Comments at 21.

95 SpaceX Comments at 4-5.

96 Kellogg & Sovereign Comments at 18.

gathered from RHC funding requests, which can be expected to exponentially improve rural healthcare providers' ability to make cost-efficient purchases.

Alaska Communications also supports a requirement that HCPs provide follow-up information describing how the services supported by the RHC program were used, whether the services purchased met the HCP's demands in real-world utilization, and whether changes or upgrades are foreseen. As ADS argues, "In order to eliminate waste[,] fraud and abuse, actual consumption or utilization become important."[97]

B. Backstopped by These Safeguards, the Commission Should Rely on Market Forces to Establish the Rural Rate for Telecommunications Services

The record reflects a strong consensus that the Commission must overhaul its rules for establishing the "rural rate" supported by the RHC Telecom Program. Two decades of evolution in market conditions and the regulatory framework have rendered the Commission's current rules unworkable, particularly in Alaska. As important as the RHC Telecom Program is to the delivery of healthcare in rural Alaska (and given the Section 254(h)(1)(A) command of reasonable rate comparability), the Telecom Program must be preserved. And, for the Telecom Program to continue to function, the Commission must adopt new standards for setting the rural rate that reflect today's market conditions and rate regulation, while remaining simple for USAC to administer.

The Telecom Program's "rural rate" rules in effect today are utterly unworkable in today's world of packet-switched, competitively priced, customizable telecommunications services that can be offered in nearly infinitely adjustable bandwidths. Nowhere is this more evident than in USAC's Rural Health Care Division today, where the beleaguered staff have

[97] ADS Comments at 2.

spent the past eight months in an effort to perform compliance review on the 2017 Telecom Program funding requests, with not a single positive decision to show for it. (Indeed, the USAC staff appear to be compounding the difficulty by interpreting the rural rate rule extremely narrowly.) The Commission should immediately grant a blanket waiver or other flexibility to enable commitments for Funding Year 2017 (and likely Funding Year 2018) to move forward, and commit itself to adopting modern, workable Telecom Program rural rate rules before the Funding Year 2019 cycle commences.

Section 54.607 of the Commission's rules offer three alternative methods for establishing a rural rate, none of which works in today's environment.[98] *First,* as the primary option, Section 54.607(a) states that the "rural rate" supported by the Telecom Program:

> Shall be the average of the rates actually being charged to commercial customers, other than health care providers, for identical or similar services provided by the telecommunications carrier providing the service in the rural area in which the health care provider is located. The rates included in this average shall be for services provided over the same distance as the eligible service. The rates averaged to calculate the rural rate must not include any rates reduced by universal service support mechanisms.[99]

Such an average undoubtedly seemed easy to determine in 1997, when the supported services primarily consisted of a limit set of point-to-point circuit switched commodity transport services offered under tariff primarily by ILECs in rural markets with nascent competition. In 2017, it is virtually impossible to determine a point average of this type. An explosion of packet-switched transport alternatives have replaced legacy circuit-switched DS-1 and DS-3 offerings, and few if any are offered at standard prices or configurations. These packet-switched options have widely differing capabilities, functions, and price points, and target the specific needs of different

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98 *See generally* Alaska Communications Comments at 43-44 (describing the ways in which the "rural rate" rules no longer work in today's environment).

99 47 C.F.R. § 54.607(a).

classes of customers. Dedicated Internet Access offers a "best efforts" connection to the public Internet. Ethernet can be offered to interconnect multiple points on a Wide Area Network, with differing service quality commitments according to the customer's needs. MPLS adds additional network security and service reliability, meshed architecture to avoid packet "flooding," and differentiated QOS to make the most efficient use of limited bandwidth.[100] And, all of these options can be offered in virtually infinite bandwidth increments. In rural and Bush Alaska, there are very few commercial customers, particularly for unsubsidized services; the chance that any of them purchases a packet-switched transport service that is "identical or similar" to the one chosen by the HCP in the area is vanishingly small. Certainly, there is no sufficient data set to create a meaningful "average" at any given bandwidth.

Second, under Section 54.607(b), in cases where the service provider does not provide any identical or similar services in the rural area where the HCP is located, the "rural rate" shall be:

> [T]he average of the tariffed and other publicly available rates, not including any rates reduced by universal service programs, charged for the same or similar services in that rural area over the same distance as the eligible service by other carriers.

As competition has emerged more fully for telecommunications services, the Commission has increasingly relied on market forces to ensure efficient pricing. Since 1997, the Commission has steadily increased pricing flexibility and withdrawn tariff requirements. And, today's plethora of modern, customizable, packet-switched transport alternatives offering differing capabilities and small bandwidth increments would be difficult to reduce to a tariff or publicly-available rate sheet in any event. Any attempt to do so would inevitably reduce the range of choices available to rural

[100] Alaska Communications Comments at 32-33.

HCPs, and lead to sub-optimal purchasing decisions.[101] Moreover, in a competitive market, even a virtual duopoly such as rural Alaska, service providers treat their pricing as confidential and competitively sensitive; as a result, there is often no "publicly available rate" either.

> *Third*, and finally, Section 54.607(b) provides that:
>
> If there are no tariffed or publicly available rates for such services in that rural area, or if the carrier reasonably determines that this method for calculating the rural rate is unfair, then the carrier shall submit for the state commission's approval, for intrastate rates, or the Commission's approval, for interstate rates, a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner.

In the twenty years that this option has been offered under the Commission's rules, Alaska Communications is unaware of any service provider or regulator that has attempted to use it, and with good reason. The competitive bidding requirements only require HCPs to wait 28 days before selecting a service provider; there is no practical way for a service provider to obtain either FCC of state commission approval of a cost-based rate within that time period. Furthermore, the mere act of requesting approval could taint the competitive bidding process, if the rate contained in the bid were made public in the regulatory proceeding. Moreover, as discussed below, there is no generally accepted way to make a meaningful determination of the cost to serve an individual customer with a multi-product, integrated telecommunications network with substantial joint and common costs, for which there is no particular allocation that is more economically efficient than any other.[102]

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[101] For example, if an HCP needs bandwidth greater than one DS-3, or its bandwidth or service needs do not correspond precisely to one of the bandwidth increments for which a service provider has chosen to publish a rate, it may not be able to establish a "rural rate" for the service it needs.

[102] *See, e.g., Implementation of the Local Competition Provisions in the Telecommunications Act of 1996*, CC Docket No. 96-98, Report and Order, FCC 96-325, 11 FCC Rcd 15499 (1996), at ¶ 678 (observing that "it is difficult for regulators to determine an economically-optimal allocation of any such joint and common costs") (subsequent history omitted).

The three regulatory backstops discussed above would create the necessary conditions to allow the Commission otherwise to rely fully on the competitive bidding process and market forces, instead of archaic tariff-based concepts, to discipline rural rates.

1. New Rules Should Reflect the Profound Changes in the Regulatory Landscape, Telecommunications Service Options, and Competitive Climate Since 1997

Twenty years ago, when the Commission established the RHC Telecom Program to support the difference between urban and rural rates for telecommunications services, the market largely consisted of circuit-switched voice telephony and TDM point-to-point transport services, at DS-0 and DS-1 speeds.[103] In fact, as originally conceived, the Commission limited support under the Telecom Program to a maximum of one DS-1 circuit, providing 1.544 Mbps, finding that "transmission speeds above 1.544 Mbps are not necessary for the provision of health care services at the present time, and their cost outweighs the additional benefits they offer."[104]

The world in which the Commission designed the three Section 54.607 methods for establishing rural rates no longer exists. In 1997, rates for DS-1 and DS-3 TDM transport services were tariffed, later subject to zone-based deaveraging, and typically included mileage-based rate elements.[105] The Commission found that it would be "relatively easy to . . . ascertain

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[103] USTelecom Comments at 13.

[104] *First Universal Service Order* at ¶ 623. In the same Order, the Commission similarly found that, "POTS lines can be used to access sophisticated information services," *id.* at ¶ 600, further illustrating the extent to which the passage of time has altered these markets.

[105] *See, e.g., Access Charge Reform*, CC Docket No, 96-262, First Report and Order, FCC 97-158, 12 FCC Rcd 15982 (1997), at ¶ 153 ("We conclude that both entrance facilities and direct- trunked transport services should continue to be priced on a flat-rated basis and that charges for these services may be distance-sensitive."); *Access Charge Reform*, CC Docket No. 96-262, Fifth Report and Order and Further Notice of Proposed Rulemaking, FC 99-206, 14 FCC Rcd 14221 (1999), at ¶ 19 ("in response to changing market conditions, we grant price cap LECs immediate flexibility to deaverage services in the trunking basket and to introduce new services on a streamlined basis").

precisely the applicable rate"[106] for urban rates (and presumably rural) using rate or exchange maps that are filed with the carrier's tariffs.[107] The competitive bidding process was intended merely to ensure that schools, libraries, and rural health care providers were "informed about all of the choices available to them," as wireless, cable, and other competitive entrants entered newly-opened telecommunications markets previously served by monopolies.[108]

Today, HIPAA patient privacy requirements, heightened network security concerns, threats of cyberattack, evolving telemedicine capabilities, heightened standards of medical care, and federal mandates to implement Electronic Health Record capabilities have transformed the needs of rural HCPs.[109] Today, virtually all HCPs need higher bandwidth services that incorporate higher security and greater reliability than TDM transport can offer, and overwhelmingly choose packet-switched connectivity in the form of highly reliable and secure MPLS service.

As the record reflects, the past two decades have seen the market for transport services grow more competitive, as new entrants have entered the market, and more diverse, as circuit-switched DS-1 and DS-3 transport services have given way to a myriad of higher bandwidth

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106 *First Universal Service Order* at ¶ 671.

107 *Id.* at ¶ 671, n.1768.

108 *First Universal Service Order* at ¶¶ 479-480, 686.

109 *E.g.,* AK Child & Family Comments at 1 (noting "increased technology and telecommunications demands due to our HIPAA legal obligations"); Alaska Trial Administrators Ass'n Comments at 1 (same); Alaska State Hospital and Nursing Home Ass'n Comments at 1 (same); American Academy of Dermatology Association Comments at 2 (noting need for patients to "communicate with their providers concerning their healthcare information in a HIPAA compliant way); National Judicial Opioid Task Force Comments, Attachment: "Teleservices: Happening Now!" at 6 ("Teleservices projects are subject to the same participant confidentiality laws as traditional treatment modalities. Therefore, teleservices initiatives must be compliant with the [HIPAA] regulations contained in 42 CFR Part 2."); GCI Comments at 13 (noting that electronic health records must comply with HIPAA patient privacy requirements).

optical and packet-switched alternatives. As these developments unfolded, the Commission incrementally rolled back its dominant carrier *ex ante* pricing and tariffing regulations to reflect growing reliance on market discipline.[110]

Today, packet-switched transport services, such as MPLS and Ethernet, are not typically tariffed, and the Commission has relied instead on competition to impose market discipline on rates.[111] Just last year, the Commission adopted a mandatory de-tariffing framework that applies to all business data services.[112] Furthermore, in a competitive environment, a service provider's rates, terms, and conditions of service are routinely considered competitively sensitive in nature.[113]

2. USAC Is No More Able to Regulate Rates for Business Data Services than the FCC, and Should Not Be Asked to Do So

In the *BDS Order*, the Commission determined *not* to impose price regulation on business data services other than a small number of DS-1 and DS-3 services in noncompetitive counties.[114] In doing so, the Commission accurately found that:

> [I]t is very difficult for . . . a regulator to estimate the efficient price level in a business with the following characteristics: high uncertainty due to frequent and often large unforeseen changes in both customer demand for services and network technologies that are hard to anticipate and hedge against in contracts with customers; a complex set of

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110 *See Business Data Services in an Internet Protocol Environment*, WC Docket No. 16-143, Report and Order, FCC 17-43, 32 FCC Rcd 3459 (2017) at ¶ 7 (citing numerous decisions granting price cap incumbent LECs pricing flexibility and forbearance from dominant carrier regulation, including tariffing and price cap regulation, for their newer packet-based and higher bandwidth optical transmission broadband services) ("*BDS Order*").

111 *See e.g.,* GCI Comments at 28 ("Today, no packet-based business data services are subject to rate or tariffing regulation. Indeed, in the vast majority of the country, even DS-1 and DS-3 special access services are being mandatorily detariffed. The Commission now relies on the market, not regulation, to determine rates for packet-based services."); TeleQuality Comments at 15; Kellogg & Sovereign Comments at 8.

112 *BDS Order* at ¶ 88.

113 It is no accident, for example, that GCI publishes transport rates on its TERRA network, but not elsewhere in Alaska, given that it has monopoly control of the market in communities served by TERRA.

114 *BDS Order* at ¶ 179.

> products and services, which are tailored to individual buyers; costs of provision that vary substantially across different customer-provider combinations; and large irreversible sunk-cost investments that a provider is required to make before offering service. In these circumstances, efficient prices are often tailored to individual purchasers, and are often subject to renegotiations that account for changing circumstances. Moreover, in these circumstances, the efficient price level, which must be reflected in the price cap, is extremely difficult to determine, not least because it must reflect the option value of sinking network investments in a rapidly-changing environment.[115]

The Commission thus wisely recognized the difficulty of the task, the great risk and consequences of regulatory error, and the harms to competition from strict price regulation and tariffing requirements. Indeed, with particular resonance for the current Telecom Program rules requiring rural rates to be established based on rates being charged to other commercial customers, or other tariffed or publicly-available rates "in the rural area" where the HCP is located,[116] the Commission found in the *BDS Order* that rate regulation "can force, through required averaging (such as the geographic average required in our price caps), prices that are too low in some locations and too high in others. The effect is to rule out entry in the former case, and to sometimes encourage inefficient entry in the latter."[117]

The Commission should not thrust upon USAC the unenviable task of determining the reasonableness of rates for packet-switched telecommunications transport services in such an environment. The Commission has recognized the great potential for rate regulation to cause harmful distortion of the market. It has, moreover, wisely judged itself unequal to that central planning task, despite nearly a century of experience in common carrier rate regulation and a specialized staff of dedicated attorneys, economists, and other experts in the theory and practice

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[115] *Id.* at ¶ 127; *see also* GCI Comments at 34. For these same reasons, support for rural rates contained in evergreen contracts should not be "reset" during the contract term, TeleQuality Comments at 17.

[116] 47 C.F.R. § 54.607(a-b).

[117] *BDS Order* at ¶ 127.

of telecommunications service pricing. The Commission should not instead thrust USAC, which lacks both the resources and the experience of the Commission, into that role.

This is particularly true in Alaska, where boroughs (the rough geopolitical equivalent of counties or parishes in the lower 48 states) are large and geographically diverse. Costs of service can vary greatly, even for two potential customers that are relatively near to one another in the same borough. As Yukon-Kuskokwim Health Center observes, "[m]yriad geographic and other factors unique to any particular rural health care provider may result in a calculated rural rate that appears unusually high, but that nonetheless is justified."[118] And, in a state where local exchange carriers ("LECs") do not have ubiquitous networks, but rely on other long-haul carriers for middle-mile transport services between the communities they serve, a service provider's costs can vary greatly based on the distance between the rural HCP customer and the nearest point of interconnection to the service provider's core network, and the latter has no control over third-party charges for middle-mile transport necessary to deliver the service.[119] Often there is only a single option for that middle-mile transport. The same holds true where the service provider must purchase tail circuits from another LEC to deliver service to a rural healthcare customer. Thus, rates in Alaska can vary widely based on factors unique to each location served.

Given the lightly regulated nature of the market for packet-switched services used by rural HCPs, the great variability in costs from one location to another in Alaska, and the relatively small number of unsubsidized commercial customers against which to benchmark, the

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[118] Yukon-Kuskokwim Health Center Comments at 3; *see also* TeleQuality Comments at 16 ("[D]irecting USAC to establish rural rates is fraught with pitfalls. Rates are dependent upon geography, topology and density, so averaging does not typically work for rural areas.").

[119] *See generally* ADS Comments at 2 ("Middle mile and last mile options need to be addressed, especially in remote locations").

Commission's various proposals for identifying funding requests that will be subject to "enhanced review" and a requirement for carriers to "justify the underlying costs in the rural rate presented in the funding request" miss the mark.[120] Alaska Communications agrees with GCI that it would be extremely difficult to make a meaningful assessment of the cost of serving a single customer using a telecommunications network offering a host of other services to many other retail and wholesale parties.[121] Telecommunications inherently involves a high proportion of joint and common costs. Even traditional rate-of-return regulation does not capture the cost of serving an individual customer. Rather, rate-of-return regulation attempts to distribute a small subset of telecommunications carrier costs across a set of regulated services in such a way that projected aggregate revenues will roughly recover those costs and provide an opportunity to earn a reasonable margin. Moreover, it is built on a complicated foundation that melded economic principles with political goals. Thus, ILEC "costs" for regulatory purposes are determined based on highly specialized regulatory cost accounting (Part 32),[122] cost allocation between regulated and unregulated services (Parts 32 and 64), jurisdictional separations of regulated costs (Part 36, which has largely frozen separations for decades), and a regulated rate structure for certain types of services (Part 69, in the case of interstate access services). Changes in interstate and intrastate rate regulation have rendered many of these regulations obsolete.

Moreover, competitive entrants have never been subject to this framework and, even for ILECs, it does not apply to the packet-switched services purchased by HCPs. Without an

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[120] GCI Comments at 23.

[121] GCI Comments at 32.

[122] The Commission has granted forbearance from Part 32 for price cap carriers, and it has never applied to non-ILECs, *Comprehensive Review of the Part 32 Uniform System of Accounts*, WC Docket No. 14-130, Report and Order, FCC 17-15, 32 FCC Rcd 1735 (2017), at ¶ 12.

explicit framework to apply, of the sort described above, USAC simply will have no authority for analyzing whether the provider's costs make a rural rate set by the competitive market "too high" or "too low."

The Commission's rules clearly require that USAC administer the RHC support mechanism solely in accordance with Commission directives, and "may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress."[123] Without explicit and detailed guidance on which costs to evaluate and how, every "enhanced review" of a funding request will become a prohibited policymaking adventure for the ill-equipped USAC staff.[124]

3. The Commission Should Align Telecom Program and HCF Bid Evaluation Rules by Requiring Price to Be a Primary Factor When HCPs Select a Service Provider

Alaska Communications agrees with USTelecom and others that price should be *a* primary factor (but not to the exclusion of other criteria) for HCPs evaluating bids to provide services supported by the RHC Telecom Program. This would align the Telecom Program rule with the rule currently in place for the HCF.[125] Because different services are supported under the Telecom Program and the HCF, some HCPs issue requests for a portion of their services to be supported by each, for example, MPLS telecommunications service to be supported by the

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[123] 47 C.F.R. § 54.702(c).

[124] *See* ANTHC Comments at 9 ("Alaska has extremely high costs for connectivity due to a wide range of reasons that are well known and justified"), 11 ("Alaska should be left out of the "benchmark" contribution/discount rate discussion until the FCC studies the state in greater detail to understand what the specific impacts would be."); TeleQuality Comments at 11, 14, 16-17 (rates should not be governed by USAC's "subjective" evaluation).

[125] *See* USTelecom Comments at 19. Under HCF, other bid evaluation criteria may have the same weight as price, but none may be more heavily weighted.

Telecom Program, and Dedicated Internet Access to be supported by HCF. It would facilitate review of these bids for the same standards to apply to each.

Alaska Communications disagrees with TeleQuality that price should be *the* primary factor considered by HCPs, as is the case with the E-rate program.[126] As the Commission explained when it created HCF:

> The Commission does not require HCPs to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their health care needs. Furthermore, initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of future medical and technological developments and maintenance. Therefore, unlike the E-rate program, the RHC program does not require participants to consider price as the primary factor in selecting a service provider.[127]

Because of the greater emphasis on performance of services supported by the RHC support mechanism, where lives are literally at stake, it differs from E-rate, which places a greater emphasis on cost. As a number of commenters point out, factors other than cost are important to ensure that rural HCPs have access to the telecommunications service they need (as required by the Communications Act).[128] In addition to bandwidth and speed, HCPs increasingly focus on latency, network reliability, route redundancy, security and service guarantees.[129] The Telecom Program is similar to HCF in this regard. Thus, the Commission should adopt the HCF rule (price as *a* primary factor), not the E-rate rule (price as *the* primary factor), for the Telecom Program.

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[126] *See* TeleQuality Comments at 21. Under E-rate, price must be the bid evaluation criterion with the single greatest weighting.

[127] *Healthcare Connect Fund Order*, FCC 12-150, at ¶ 221.

[128] *E.g.,* ADS Comments at 2 & 4 (cost-effectiveness is not synonymous with least-cost).

[129] *E.g.,* FHA/PHS Comments at 5-6 & 14-15; TeleQuality Comments at 20-21. *See also* ADS Comments at 4 (price should not be required to be dominant factor; vendor experience and other factors also relevant to selection for a RHC project).

C. Urban Rates Should Be Set by USAC

Alaska Communications agrees with the many commenters that support a rule under which USAC would establish the urban rate for purposes of the urban-rural price difference for Telecom Program projects. This change could significantly improve the RHC Telecom Program, making it administratively simpler.[130]

Today's urban rate standard, defined as a ceiling with no ascertainable floor,[131] invites HCPs to evaluate bids based on competing service providers' estimates of the urban rate applicable to their services.[132] Establishing an urban rate benchmark – whether state-specific or national – would eliminate one pricing variable and a potential source of considerable delay arising during USAC's review of Telecom Program funding requests. As the National Rural Health Association explains, requiring each HCP to determine the urban rate independently, which typically involves the engagement of outside consultants and other resources, creates duplicative work for service providers as well as USAC, adding substantial inefficiency to the

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[130] *See, e.g.,* ADS Comments at 3 ("If it is agreed the urban rate is similar across all geographic urban areas, then use a single urban rate in order to determine the discount rate. The urban rate could be the average cost of service in the largest 25 Metropolitan Service Areas. One urban rate may simplify the determination of discount process, make pricing more transparent, and eliminate some of the work required by the Administrator in terms of reviewing applications."); SpaceX Comments at 4-5 ("[L]imiting the urban rate to an average rate for a functionally similar service offered in a city of 50,000 or more in the state would similarly provide an objective and independently verifiable standard. For both rural and urban rates, a USAC database of rural and urban rate data, based on public sources, will eventually make it faster and easier for applicants to show that their proposed rates are representative of what would be charged for a service in the area.").

[131] 47 C.F.R. § 54.605(a) (defining the urban rate as "a rate *no higher than* the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city") (emphasis added).

[132] *See* TeleQuality Comments at 12 (arguing that, "[i]f the Commission or USAC establishes urban rates, the possibility of manipulation of the urban rates will essentially be eliminated"); ADTRAN Comments at 7; National Rural Health Ass'n Comments at 5-6.

funding process.[133] USAC is better positioned to determine urban rates for all the nation, and by doing so it can take unnecessary time and expense out of the funding process.

In Alaska Communications' experience, Anchorage rates are much lower and less variable in price (among services offering similar bandwidth and performance characteristics) than are rural rates. Therefore, a uniform urban rate established by USAC for all services offering similar capabilities would provide administrative simplicity without sacrificing accuracy. For example, as described above,[134] Dedicated Internet Access, Ethernet, and MPLS and Ethernet each offer differing functionality and should be similarly differentiated for purposes of computing Telecom Program support.

Moreover, as fewer and fewer services are offered under tariff or other publicly-available lists, service providers and HCPs alike have diminishing visibility into market-wide urban rates. Only USAC has comprehensive data from all service providers upon which to draw in determining urban rates.[135] And, as TeleQuality explains, certain E-rate data may provide a useful resource for this purpose.[136]

III. Within this Framework, the Commission Should Adopt Complementary Reforms to Modernize the RHC Support Mechanism

The record reflects support for additional reforms to further improve the Telecom Program and complement those more substantial changes discussed above. Administrative delays, while sometimes unavoidable, have become a serious problem for HCPs in Alaska.

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133 National Rural Health Ass'n Comments at 4-5.

134 Section II.B., above.

135 *See* NCTA Comments at 5.

136 TeleQuality Comments at 15 ("Urban rates should be fairly easy for the Commission to establish. While tariffed rates are now not readily available for many eligible services, the Commission could use rates charged to E-rate recipients to determine an urban rate.").

Rural HCPs that participate in consortia or are relatively close to urban areas may have resources that Alaska's rural HCPs simply lack. The Commission should act as quickly as possible to adopt the reforms supported herein and resume the flow of vital RHC funding.

A. The Record Reflects Support for Sensible Reform of the USAC Rural Health Care Division's Administrative Processes

Seemingly interminable delays in announcing RHC funding commitments have now obstructed the support mechanism's mission, imposed substantial and unforeseen costs, created grave uncertainty, and sown confusion for two funding years in a row. Reforms to modernize the Telecom Program and increase the budget will undoubtedly alleviate some of these issues. But, USAC's lack of transparency and accountability in their processes – and their failure to provide even basic information as to their progress or factual information on the number of applications processed or aggregate demand – have caused substantial difficulties in their own right.

Thus, Alaska Communications has advocated for the Commission to impose basic transparency and accountability mandates on the USAC Rural Health Care Division, and supports others who have raised similar concerns in the record.

First, the Commission should require USAC to adhere to standard timetables and deadlines in accepting funding requests and, more importantly, issuing funding decisions. As the record indicates, the Commission should:

- Create standard filing windows for RHC funding requests, which remain constant from year to year and close sufficiently in advance that funding commitments can be issued before the funding year starts;[137]

[137] *See* USTelecom Comments at 21 (urging the Commission to "establish a consistent year-to-year schedule of funding period windows, with the first closing sufficiently in advance of the July 1 beginning of the funding year so that USAC can issue all funding decisions before the new funding year starts"); TeleQuality Comments at 23 (arguing that "HCPs should be

- Codify deadlines for USAC issuance of funding decisions and appeals;
- Require USAC to make information related to RHC administration public and readily accessible through the USAC website, including basic information about the status of the Rural Health Care Division's progress in reviewing funding requests, remaining time to issue decisions, and basic statistics regarding the number of funding applications received and total requested funds;[138] and
- Direct USAC to issue funding decisions and evergreen designations on a rolling basis, even if funding amounts remain contingent upon a to-be-determined *pro rata* factor if one becomes necessary.[139]

Only by instituting such changes can the Commission uphold the mandate of Section 254 that support be specific, predictable, and sufficient to achieve the mandate the RHC Telecom Program.[140] In its comments, Alaska Communications offered sample timelines that it believes should work efficiently, but the key point is to establish *some* framework and system of deadlines and performance benchmarks for USAC that ensure accountability, transparency, and timeliness of decisions.

B. The Commission Should Prioritize Funding to Rural HCPs, but May Not and Should Not Prioritize Funding for Any Class of Rural Healthcare Providers under the Telecom Program

Section 254(h)(1)(A) makes clear that the Telecom Program is mandatory and requires sufficient funding to ensure reasonable comparability of rates paid by rural HCPs and those

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allowed to seek bids earlier than January 1 of a funding year so the bidding process timeframe is not so short," and that "timely commitments should be one of the Program's primary goals"); FHA/PHS Comments at 18 (requesting that "filing window periods be fixed well in advance to enable applicants to most effectively manage their RHC Program participation").

[138] SHLB Comments at 32; USTelecom Comments at 21.

[139] USTelecom Comments at 21; SHLB Comment at 32; New England Telehealth Consortium Comments at 6 (supporting "processing deadlines that would require USAC to issue funding decisions, or at least some type of provisional funding award notice, within 90 days of receiving an application").

[140] USTelecom Comments at 20.

prevailing in urban areas. The statute does not permit differentiation between "shades" of rural, whether based on budget constraints, tiers of "rurality," classes of HCPs, or other factors. To the extent that the Commission constrains funding, it may only do so in the HCF Program. For that reason, Alaska Communications opposes commenters who suggest that the Commission adopt rules to prioritize Telecom Program funding based on degrees of "rurality" or other criteria.[141] The statute simply does not permit the Commission to discriminate among rural HCPs in that way under the Telecom Program.

Nor would such prioritization represent sound public policy. The communities of western Alaska served by TERRA are among the "most rural" in the nation, and would be the first to receive priority under virtually any tiering system, notably including the "Highly Rural" classification proposed by GCI and tiers based on the prongs of the Commission's current definition of "rural."[142] As discussed here and elsewhere, TERRA rates are among the very highest in the nation, and reflect the worst impulses of an abusive unregulated monopolist. Merely limiting those rates to the prevailing rates for functionally similar satellite service would save the program tens of millions of dollars every year, through that change alone. For the Commission to adopt rules to *prioritize* funding for TERRA over virtually all others would

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[141] The Commission has considerably greater discretion in the context of HCF, because Section 254(h)(2)(A) permits the Commission to consider the degree to which that program is "technically feasible and economically reasonable." For that reason, the Commission may (and should) prioritize HCF support for rural HCPs over urban HCPs that are eligible to participate as members of consortia. *See* National Rural Health Ass'n Comments at 4 ("While NRHA is not proposing a complete bar to urban participation, funding must be demonstrated to be purely for the benefit of the rural participants in the consortia."); National Association of Community Health Centers Comments at 3 ("Well-intentioned efforts to encourage rural-urban consortia have often not achieved the intended benefits [and] have resulted in increased administrative burdens, and diverted RHCP funds from CHCs (and other eligible providers)" in favor of non-rural HCPs.).

[142] GCI Comments at 43-44, 47.

perpetuate the waste, siphon funds that could be properly used elsewhere, and prolong the burden on contributors that TERRA continues to impose.[143]

C. Changes to the definition of "rural" are unwarranted

As a general matter, Alaska Communications does not believe that changes to the definition of "rural" used for the RHC support mechanism, as some commenters propose, are warranted.[144] The Commission's current definition has been in place for many years, and it is working well to appropriately define the scope of eligibility in Alaska. Among the many alternative definitions, none has been shown to be so clearly superior that it warrants the disruption and dislocation that would inevitable accompany the change.[145]

Alaska Communications therefore agrees that any change to the definition of "rural" should add to the eligibility criteria, and should not replace the current definition.[146] The American Hospital Association cautions, for example, that changes following the 2010 census caused some areas to lose rural status "irrespective of whether the affected populations have

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[143] *See* Community Hospital Corp. Comments at 1 ("CHC does not agree to a tiered or prioritization based approach. Instead, we affirm that the current pro rata mechanism promotes fair funding practices for applicants.").

[144] *See* American Hospital Ass'n Comments at 16; NHeLP Comments at 5; SHLB Comments at 16-17; National Ass'n of Community Health Centers Comments at 3.

[145] *See* Community Hospital Corp. Comments at 2 (explaining that ["[t]he definition of rural area in §54.600(b) of the Commission's rules meet the needs of the RHC Program and CHC does not support any update or modification to the definition"); Critical Access Hospital Coalition Comment at 2 (noting that "[t]he definition of rural area in §54.600(b) of the Commission's rules meet the needs of the RHC Program and the CAH Coalition is concerned about any update or modification to the definition"); SHLB Comments at 17; Kellogg 7 Sovereign Comments at 7.

[146] *See, e.g.,* American Telemedicine Ass'n Comments at 2 (arguing for "use of the broadest conceivable definition of rural for those aspects so restricted by statute"). SHLB raises the potential for the Commission to revisit the use of Rural-Urban Commuting Area ("RUCA") codes in defining "rural" areas eligible for support, *see* SHLB Comments at 17. If the Commission were to prioritize support based on RUCA codes, Alaska Communications believes that Codes 7-10, inclusive, should all be placed in the highest tier.

gained better access to health resources."[147] To the extent that the Commission determines that any change to the definition of "rural" has merit, it should become an additional way for HCPs to qualify as rural, but not exclude any HCP that qualifies under the current definition.

D. The Record Contains Strong Support for Making Patient Home Monitoring Services Eligible for Support

Alaska Communications enthusiastically welcomes the support of those commenters that, like ourselves, believe that patient home monitoring services should be eligible for support under the RHC Telecom Program. Patient home monitoring and treatment, such as the "Hospital at Home" program, improve patient outcomes and reduce costs.[148] As recently reported:

> New York's Mount Sinai Hospital has developed a hospital-at-home program, HaH-plus, for some patients who show up at the emergency department or are referred by their primary-care doctors. A mobile acute-care team provides staffing, medical equipment, medications and lab tests at home, and is on call 24/7 if a condition worsens . . . . *Mount Sinai estimates that nationally, 575,000 cases each year could qualify for such a program, and treating just 20% of those could save Medicare $45 million annually.*[149]

Viewed in this light, ADTRAN's concerns regarding this "significant expansion" of the RHC support mechanism appear to be unfounded.[150] As Alaska Communications explained in its initial comments, the cost is likely to be modest, and will produce outsize savings compared to chronic (or even acute) care in traditional hospitals or other medical settings. And, the Commission has consistently found that a telecommunications service with at least one end at the

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[147] American Hospital Ass'n Comments at 17.

[148] *See, e.g.,* HIMSS/PCHAlliance Comments at 1-3; Connect Health Initiative Comments at 2-3, 7; AANA Comments at 3; SHLB Comments at 19; Satellite Industry Ass'n Comments at 3-4; CHRISTUS Comments at 3, 5; HealthIT Now Comments at 1; FHA/PHS Comments at 4; American Hospital Ass'n Comments at 10).

[149] Laura Landro, "The Future of Hospitals," *The Wall Street Journal* (Feb. 26, 2018), at R1 (emphasis added).

[150] ADTRAN Comments at 5.

rural HCP is eligible for support.[151] A local connection between the patient's home and the rural HCP is unlikely to be costly; thereafter, if the monitoring data must be transmitted to a distant specialist, it can travel on the existing connection for which the rural HCP is already eligible.

E. The Commission Must Act Without Delay

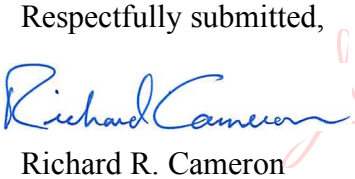
The Commission has rightly opened this proceeding with a comprehensive examination of all aspects of its RHC support program. Now, it must act. This program is praised in Alaska for the life-saving work it has accomplished in remote Bush villages and other rural communities. Today, however, it also has become the source of great consternation. The continuing delays resolving Funding Year 2017 applications (and even some Funding Year 2016 applications) no longer can be ascribed merely to administrative complexity or heavy workloads. They have raised questions about whether this Commission's intentions are consistent with the mandates of the Communications Act. They have created a veritable crisis for healthcare providers, at least in Alaska. And every day that goes by without action wreaks further havoc for healthcare and telecommunications service providers alike.

[151] 47 C.F.R. § 54.613(a); *Healthcare Connect Fund Order* at ¶ 137.

Conclusion

For the foregoing reasons, the Commission should take immediate action to increase the budget for the Telecom Program and adopt necessary reforms to the rules so that rural healthcare providers have access to the telecommunications services they need at affordable rates.

Respectfully submitted,



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